IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

AMENDED DEMAND LETTER
CERTIFIED
Complaint Intake #: 36937-C
37112-A

March 20, 2013

Ms. Karen Beck, Administrator
Prairie Hills Assisted Living
5815 S.E. 27th Street
Des Moines, IA 50320

HEALTH FACILITIES

APR 03 2013

RE: NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INVESTIGATION REPORT – PRAIRIE HILLS ASSISTED LIVING

Dear Ms. Beck:

I. Final Complaint/Incident Investigation Report – Prairie Hills Assisted Living, Des Moines, IA

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a complaint investigation by DIA on December 12-15, 2011. The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Medications, Staffing and Service Plans.

Prairie Hills Assisted Living ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and (b) and 481 IAC rules 67.12(3)(a)(1) and (2).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program received a regulatory insufficiency in the area of Staffing during an October 5, 2011 on-site complaint investigation.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

In this case, the determination of a $1,000 civil penalty is based upon a repeated regulatory insufficiency in the area of Staffing, and based upon noncompliance resulting in an injury sustained by a tenant while at the program. As the enclosed Report details, the tenant sustained a large bruise on his/her hand and arm and reported the injury resulted from being grabbed by staff in an attempt to get the tenant out of bed for breakfast. The tenant's physician examined the tenant and concluded "clearly someone tried to pull" the tenant's arm.

II. Reduction of Civil Penalty

If, within 30 days of the receipt of this demand letter, you withdraw your previous request for formal hearing and pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.12(3)d. If you wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of six hundred fifty dollars ($650) within 30 days after the receipt of this demand letter.

III. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and (b) and 481 IAC 67.12(3)(a)(1) and (2). The Plan of Correction (POC) submitted on January 17, 2012, has been reviewed and will constitute the final POC related to the on-site visit of December 12-15, 2011.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Kit Steiber, Administrator
Prairie Hills Assisted Living
5815 S.E. 27th Street
Des Moines, IA 50320

Complaint/Incident Intake: 36937-C
37112-A

Date of Complaint/Incident Investigation:

December 12-15, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	31
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	36

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	4
TOTAL census of Assisted Living Program	40

Program History – The program received regulatory insufficiencies in the areas of Staffing and Food Service during the October 5, 2011 Complaint on-site (36136).

The program received a regulatory insufficiency in the area of Record Checks during the September 14, 2011 Recertification on-site.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation 37112-A: It was alleged a tenant's right hand and wrist were bruised when a staff member pulled a tenant out of bed. The tenant reported an "aide" grabbed him/her by the arm to pull the tenant out of bed. Local police conducted an investigation of possible elder abuse.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1, a 76 year old, was admitted on 10-6-11 and had diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's Dementia, Atrial Fibrillation, and History of Compression Fracture of the Lower Thoracic Spine, History of Hypertension, and Coronary Artery Disease. A Global Deterioration Scale (GDS) staged Tenant #1 at four, which indicated moderate cognitive decline. A service plan of 11-23-11 indicated Tenant #1 needed assistance with activities of daily living (ADLs), including assistance with meals, ambulation, one staff assistance with transfer, bathing, grooming, dressing and toileting. The Program administered medications. A

Pharmacy records indicated Tenant#1 was prescribed topical Fentanyl every 72 hours for back pain on 10-6-11. Tenant #1 resided in the general population.

Tenant #1 was admitted to the hospital for Pneumonia on 11-2-11 and returned on 11-8-11. A nurse review of the same date indicated no changed in health status. Nurse's notes of 11-21-11 indicated Tenant #1 refused to get up for breakfast and a meal tray was sent. On 11-22-11, at 8:00 a.m., Tenant #1 called for assistance. Staff found Tenant #1 on the floor by a chair. Staff didn't know if Tenant #1 had slid off the chair but noted the brakes on Tenant #1's walker weren't set when Tenant #1 may have tried to stand. The registered nurse (RN) evaluated and determined Tenant #1 had neither sustained an injury nor complained of pain. On 11-22-11, at 5:30 p.m. Tenant #1 called for assistance. Staff and the RN responded and found Tenant #1 on the floor. Tenant #1's walker was not close by because Tenant #1 attempted to stand, fell and rolled on the floor, away from the walker. The RN completed an evaluation and indicated no injury. Tenant #1 complained of pain and Tylenol was given. Tenant #1was assisted to a chair and was given supper. At 9:00 p.m. staff reported Tenant #1was up, had eaten supper, was given evening medications and was alert and oriented and had not complained of pain.

On 11-23-11 a late entry was made by the RN of an incident of 11-22-11 at 10:00 p.m. Staff reported they entered Tenant #1 room to assist Tenant #1to bed and found Tenant #1 drooling and having difficulty breathing. Staff called 911, family and the RN. Tenant #1was sent to a hospital emergency room for evaluation and treatment. Tenant #1was admitted for shortness of breath and Atrial Fibrillation. A hospital physical examination was conducted and no bruising was noted. Tenant #1was discharged in the afternoon of 11-23-11. Discharge instructions indicated Tenant #1 was alert and oriented to time, place and person. Speech, vision, hearing were normal and Tenant #1was independent with eating. Tenant #1 skin was intact. Tenant #1needed assistance with ADLs; including; assistance with toileting, bathing and ambulation. Physical and occupational therapy was ordered through home health.

Nurse's notes of 11-23-11 indicated the RN spoke to Tenant #1 family regarding her concern for Tenant #1's increased care level. The RN reported she "reluctantly" would take Tenant #1 back into the Program, but she would have to assess Tenant #1 to determine Tenant #1's level of care. Functional, cognitive and health evaluations were completed on 11-23-11. The health evaluation indicated Tenant #1's skin condition was normal, without any skin discolorations. Upper and lower range of motion indicated no obvious limitation.

Nurse's notes of 11-23-11 indicated the evaluations completed by the RN indicated Tenant #1's care needs were increased and cognition had declined. A series of late entries were made on 11-25-11, reporting on 11-24-11 at 8:00 a.m. Tenant #1 refused medications, toileting and breakfast. The RN instructed staff to let Tenant #1 sleep and offer a meal tray. Tenant #1 woke at 11:00 a.m. and wanted assistance with dressing. Two staff were needed to sit Tenant #1 up in bed and dress.

Nurse's notes of 11-25-11, (a late entry for 11-24-11) indicated staff reported to the RN Tenant #1's family was removing Tenant #1 and belongings from the Program that morning. The RN instructed staff to give the family Tenant #1's medication and to assist the family in any possible way.

According to police records of 11-24-11 at 1:45 p.m. Tenant #1's family contacted local police for possible elder abuse. Family reported on the morning of 11-24-11, Tenant #1 didn't want to get out of bed and alleged Staff #3 pulled Tenant #1 out of bed by using Tenant #1's right hand and wrist. A large bruise on Tenant #1's right hand and forearm was noted and photographed by police and family. Tenant #1 was later seen at a hospital emergency room for treatment. Hospital emergency records of 11-24-11 indicated Tenant #1 was diagnosed and treated for a contusion of the hand, was stable and was discharged.

Program records indicated an investigation was conducted by the Program on 11-30-11. Staff was asked a number of questions related to the care given to Tenant #1. Staff was asked if they had "any concerns regarding any staff member being rude, aggressive, etc. toward any resident." Staff #4, in a written statement, reported Staff #3 intimidated Tenant #1 to do things Tenant #1 didn't necessarily want to do.

Staff #5, in a written statement reported staff member (identified as Staff #3 during a phone interview with a monitor) was rude and harsh to Tenant #1. When Tenant #1 requested a room tray, one staff member said to Tenant #1 "all you're getting is juice and toast." During a meal in the dining room Tenant #1 was chastised for having ice cream. Another staff member (identified as Staff #1 during the same phone interview) came into Tenant #1's room while Staff #5 was present and said loudly "What did ... want." Staff #5 left and the same staff member told her "You cannot baby ... - you have to just find out what ... wants and leave."

Staff #1 was interviewed on 12-12-11 and 12-13-11. On 12-12-11 she reported Tenant #1 began to refuse cares two days after moving to the Program. Tenant #1 refused to shower, dress and toilet. The RN directed staff to redirect Tenant #1 when he/she refused services, to come back in 15 to 20 minutes or send in another staff member. Staff #1 reported staff that assisted Tenant #1 with cares was "all upset," (staff not identified) but provided appropriate care. She reported she was not aware of staff being abusive or rough with the tenant.

On 12-13-11, Staff #1 was interviewed and wrote a written statement describing the events of 11-24-11. Staff #1 arrived to work on 11-24-11 at 6:00 a.m. Approximately 8:00 a.m. she started down 300 hallway. Staff #3 had already provided care to a couple of tenants who lived in the 300 hallway when she reported Tenant #1 had complained about pain when she tried to get Tenant #1 out of bed. Staff #3 asked her if she would try to get Tenant #1 up. Both Staff #1 and Staff #3 went in together and explained to Tenant #1, Staff #1 and Staff #3 were both going to help Tenant #1 out of bed. Tenant #1 was willing and wanting to get out of bed, but Tenant #1's back and hip was hurting when they attempted to sit Tenant #1 up in bed. Tenant #1 stated it was okay to sit up, even if he/she was making sounds from hurting. Both Staff #1 and Staff #3 helped Tenant #1 sit up in bed for a couple of minutes to allow Tenant #1 to catch his/her breath. Staff #1 described how she and Staff #3 assisted Tenant #1 out of bed. Staff #1 assisted Tenant #1 to the bathroom to toilet and with personal cares. Staff #1 and Staff #3 left Tenant #1's room for a breakfast tray, returned to Tenant #1's room and placed the breakfast tray on the dining room table. Both Staff #1 and Staff #3 assisted Tenant #1 from the bathroom to the dining table. Tenant #1 thanked both staff for their assistance and both staff left. At approximately 9:30 a.m.

Staff #1 went to Tenant #1's room to pick up the breakfast tray. Tenant #1 sat in a recliner and requested medications. Staff #1 left to find Staff #3, who was administering medications to other tenants. Staff #3 came to Tenant #1's room and administered medications. Staff #1 started Tenant #1's breathing treatment. Both staff left Tenant #1 to complete his/her breathing treatment. At approximately 12:00 p.m. Tenant #1 called for assistance. Both Staff #1 and Staff #3 responded, finding Tenant #1's family in Tenant #1's room. Family requested Tenant #1's medications and told staff Tenant #1 would not be returning. Family reported "someone had been yelling" at Tenant #1 but she didn't know who it was. Staff #1 reported Tenant #1 told her he/she didn't know what family was talking about and didn't know why he/she was leaving.

Staff #3 was interviewed twice on 12-13-11. In the first interview she reported Tenant #1 routinely refused personal and health related cares. She reported Tenant #1 was difficult, as Tenant #1 wanted to lie around. Family wanted staff "to do whatever to get Tenant #1 out of bed and complete his/her cares." Tenant #1 was oppositional and "would do anything to not get out of bed" and complete cares. On 11-24-11, between 7:30 a.m. and 8:00 a.m. Staff #3 and Staff #1 went into Tenant #1's room to get Tenant #1 up. Tenant #1 refused and both Staff #3 and Staff #1 left. She went to the kitchen and ordered a breakfast tray for the tenant. She took the breakfast tray to Tenant #1's room and placed the tray on the table. She reported she went back 20 to 30 minutes later and noted Tenant #1 was eating. Staff #3 gave Tenant #1 his/her medications and left. Tenant #1 called for assistance 45 minutes later and she and Staff #1 went to Tenant #1's room. Tenant #1 was later seen at lunch time and Staff #3 had no other contact with Tenant #1.

Later the same day Staff #3 was interviewed a second time. She wrote a written statement describing the events of 11-24-11. She arrived at work at 6:00 a.m. She took the medication book for the 300 and 400 hallway. Staff #1 took the 200 hall medication book. She and Staff #1 "did our meds and cares." When it was time to go to Tenant #1's room, between 7:30 and 8:00 a.m. Staff #3 and Staff #1 knocked on Tenant #1's door, entered and found Tenant #1 sleeping. Staff #3 called out Tenant #1's name. Tenant #1 said he/she didn't want to be bothered and wasn't going to get up. Both Staff #3 and Staff #1 left the room. Staff #3 stated she went to the kitchen to get Tenant #1 a breakfast room tray. Both Staff #3 and Staff #1 put the food tray in Tenant #1's apartment on the table and told Tenant #1 a breakfast tray was brought to him/her. Tenant #1 said he/she would get up and eat. Staff #3 and Staff #1 left the room. Staff #3 came back to check on Tenant #1 and found Tenant #1 eating. Staff #3 told Tenant #1 to let her know when he/she was finished. Twenty minutes later Staff #3 saw Tenant #1 dressed and sitting in a recliner. Staff #3 stated she saw Tenant #1 sitting at the dining room table and Tenant #1's family was taking "stuff" out of the room. Staff #3 and Staff #1 assisted family with gathering Tenant #1's belongings and helped placing them in a van and helped Tenant #1 into the van.

Tenant #1 was interviewed and stated a staff member with short black hair had yelled at him/her. Tenant #1 stated he/she was sleeping and the staff person described above, woke and told Tenant #1 he/she needed to get up for breakfast. The same staff member was mad, tried to get Tenant #1 up and squeezed his/her hand. Tenant #1 stated it hurt when the staff person squeezed his/her hand. Tenant #1 couldn't give a

specific date or time of the above incident. Tenant #1 stated staff has helped him/her out of bed and chair but couldn't describe how this was done.

Tenant #1's family was interviewed and reported on 11-24-11 family arrived at the Program at approximately 12:00 p.m. Family informed staff Tenant #1 would not be returning that day to the program. Staff #3 asked why Tenant #1 wouldn't be returning and family reported to her someone was mean to Tenant #1 and family did not appreciate it. Staff #3's reply was it was her and she felt she was motivating the tenant. Approximately 12:20 p.m., while en-route to a family member's home Tenant #1 was told he/she wouldn't be returning to the Program. Tenant #1's reply was "Oh, God no, look what she did to me this morning." At that time Tenant #1 showed family his/her right arm. Tenant #1 had a large bruise on his/her right hand and arm. Family asked Tenant #1 what had happened and Tenant #1 replied Staff #3 had grabbled and squeezed his/her arm in an attempt to drag him/her out of bed for breakfast even though he/she had told staff he/she didn't want to eat at that time.

Tenant #1's physician was interviewed and reported Tenant #1 was seen in his office on 11-30-11. It was reported to the physician Tenant #1 was sleeping and a woman came in and wanted to get Tenant #1 up for breakfast. Tenant #1 wanted to sleep but "this woman" wouldn't let her sleep. Staff grabbed Tenant #1 by the right hand and tried to pull Tenant #1 out of bed "by just yanking the right arm. The physician stated an x-ray was taken on 11-24-11, when Tenant #1 was seen at the hospital emergency room and no fracture was seen. "Clearly someone tried to pull" Tenant #1's arm as there was fingertip impressions on the anterior part of the forearm. Tenant #1's right hand was purple with bruising all over the dorsum of the hand to about two inches below the wrist. Three spots were seen on the anterior forearm, which was the size of fingertips. "Bruising could have happened the morning" of 11-24-11, with bruising being seen in the afternoon. The physician stated he had previously seen Tenant #1 during the hospitalization of 11-23-11 and noted no bruising. Tenant #1 had previously been on Coumadin but blood levels were normal.

Staff interviews, local hospital emergency room notes, Tenant #1's physician and Tenant #1's interview indicated Tenant #1 sustained an injury while residing at the Program on 11-24-11.

- Regulatory Insufficiency: All tenants have the following rights. (1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (4) to be free from mental and physical abuse. (IAC r.481-67.3(1)(4))

B. Medications

Complaint/Incident Allegation 36937-C: It was alleged a tenant ran out of medication and the tenant's family wasn't notified. It was alleged a tenant was given Xanax (Alprazolam) 0.25mg daily when the tenant's physician ordered it PRN (as needed).

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's Medication Administration Records (MARs), pharmacy delivery records and clinical notes did not indicate Tenant #1 ran out of medication. Tenant #1 was prescribed Fentanyl 12mcg/hr Transdermal patch every 72 hours on 10-6-11. MARs for October, 2011, indicated Tenant #1 received a Fentanyl patch as prescribed until 10-21-11, when it

was administered a day earlier than prescribed and not as scheduled for 10-20-11. Fentanyl was administered on 10-26-11, 10-29-11 and 11-1-11. Tenant #1 was hospitalized from 11-2-11 until 11-8-11. Hospital records indicated Fentanyl was administered on 11-8-11. MARs for November, 2011 indicated Fentanyl was administered on 11-11-11 and 11-19-11. On the back of the November MARs a note of 11-19-11 indicated Fentanyl had not been placed on Tenant #1 since 11-14-11. Controlled medication utilization record for November, 2011 indicated Fentanyl patch was signed out on 11-14-11, but the MARs for 11-14-11 did not indicate Tenant #1 received Fentanyl. Tenant #1 was hospitalized on 11-22-11 and returned on 11-23-11. Hospital discharge instructions of 11-23-11-23 indicated Fentanyl 12mcg/hr patch was discontinued.

Pharmacy records and a handwritten physician order indicated Alprazolam 0.25mg – one tablet every a.m. and one tablet at night was ordered on 11-18-11. MARs for November, 2011 indicated Alprazolam 0.25mg was administered as ordered beginning 11-18-11 until 11-23-11, when hospital discharge instructions discontinued the medication.

The Program did not administer medication as prescribed.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

C. Staffing

Complaint/Incident Allegation 36937-C: It was alleged the Program was understaffed.

- Monitoring Observation: Program records indicated two staff worked in the general population program for each of three shifts. An additional staff was assigned to the dementia unit for each of three shifts. Tenant #1 was interviewed and couldn't remember if staff was available when needed. Tenant #2 was not interviewed, as Tenant #1 was not residing at the program. Tenant's #3, #4, #5 and #6 were interviewed and reported staff was available when needed.

- Regulatory Insufficiency: None noted

Complaint/Incident Allegation 36937-C: It was alleged a staff member yelled at a tenant.

Monitoring Observation: Tenant #1 was interviewed and stated a staff member with short black hair had yelled at him/her. Tenant #1 stated he/she was sleeping and the staff person described above, woke Tenant #1 and told Tenant #1 he/she needed to get up for breakfast. The same staff member was mad, tried to get Tenant #1 up and squeezed his/her hand. Tenant #1 stated he/she said it hurt when the staff person squeezed his/her hand. Tenant #1 couldn't give a specific date or time of the above incident. Tenant #1 stated staff has helped him/her out of bed and chair but couldn't describe how this was done.

Program records indicated an investigation was conducted by the Program on 11-30-11. Staff was asked a number of questions related to the care given to Tenant #1 by staff. Staff was asked if they had "any concerns regarding any staff member being rude, aggressive, etc. toward any resident." Staff #4, in a written statement reported Staff #3 intimidated Tenant #1 to do things they don't necessarily want to do.

Staff #5, in a written statement reported staff member (identified as Staff #3 during a phone interview with a monitor) was rude and harsh to Tenant #1. When Tenant #1 requested a room tray, one staff member said to Tenant #1 "all you're getting is juice and toast." During a meal in the dining room Tenant #1 was chastised for having ice cream. Another staff member (identified as Staff #1 during a phone interview) came into Tenant #1's room while Staff #5 was present and said loudly "What did ... want." Staff #5 left and the same staff member told her "You cannot baby ... - you have to just find out what ... wants and leave."

Tenant #2 was interviewed and stated Staff #3 would be short and "was quick with," him/her. Staff #3 was rough and pulled Tenant #2 up when lying in bed or sitting in a chair. Staff #3 would rush Tenant #2 when giving assistance with cares and didn't like Staff #3's attitude. Staff #3 had yelled at Tenant #2 in the past. Staff #3 would get Tenant #2 up in the morning, threw the bed covers back and pulled Tenant #2 up from bed. "It would hurt but not much." Staff #3 would yell at Tenant #2 and tell Tenant #2 to get up. Tenant #2 stated he/she complained to the head nurse, before the current RN came to the Program and Staff #3 didn't help him/her any longer.

Tenant #1 and Tenant #2 and Staff #4 and Staff #5 reported staff were not appropriate in the cares they gave.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

D. Service Plans

Complaint/Incident Allegation 36937-C: It was alleged a tenant had fallen a number of times and this was unusual.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's nurses notes of 10-6-11 through 11-21-11 indicated Tenant #1 had not fallen. Nurse's notes of 11-22-11 indicated Tenant #1 was suspected of falling on 11-22-11 on two separate occasions, once at 8:00 a.m. and again at 5:00 p.m. At 8:00 a.m. Tenant #1's call light went off. Staff responded and found Tenant #1 on the floor by a chair. Tenant #1 didn't know if he/she slid off or what had happened, but the brake on Tenant #1's walker wasn't engaged. Staff surmised Tenant #1 tried to stand and ended up with his/her legs straight out. The RN completed a nurse review and determined Tenant #1 was not injured and there was no change in ambulatory status or balance. Nurse's notes of the same date, at 5:30 p.m., noted Tenant #1's pendant alarmed. Staff and the RN responded, finding Tenant #1 on the floor. Tenant #1's walker wasn't close by and it appeared Tenant #1 attempted to stand, fell and rolled on the floor, away from the walker. The RN completed a nurse review and determined Tenant #1 was

not injured. Tenant #1 complained of pain and Tylenol was given. In both incidents the Program completed incident reports.

Tenant #1's service plan of 11-8-11 indicated Tenant #1 needed periodic assistance with ambulation for long distances, with the use of a walker and Tenant #1 was independent with transfers. A service plan was updated on 11-23-11 when Tenant #1 returned to the Program following a hospitalization. The service plan indicated Tenant #1 required constant supervision or assistance to walk, as Tenant #1 had two falls in one day. Tenant #1 required some supervision and/or one person assist with transfers.

- Regulatory Insufficiency: None noted

During the course of the investigation, the following information was obtained.

- Monitoring Observation: Tenant #1's nurse's notes of 10-13-11 indicated Tenant #1 refused to come to the dining room for breakfast and dinner. On 11-1-11, nurse's notes indicated Tenant #1 refused to get dressed and come to the dining room for lunch as Tenant #1 complained of being in too much pain. On 11-2-11 Tenant #1 was admitted to the hospital and returned on 11-8-11. Nurse's notes of 11-21-11 indicated Tenant #1 refused to come to the dining room for breakfast.

  The RN was interviewed and stated Tenant #1 refused cares beginning the two weeks from admission. Tenant #1 was difficult and refused to eat meals, refused to bathe and refused to dress for the day. Tenant #1 would refuse medications and was verbally abusive toward staff and would often call them inappropriate names. The RN stated staff were trained to deal with this behavior through their dementia training, Certified Nursing Aide (CNA) training and giving staff directives not to escalate the situation. If Tenant #1 refused their cares staff were to revisit Tenant #1 later.

  Staff LPN was interviewed and indicated Tenant #1 routinely refused personal and health directed cares. Tenant #1 routinely refused to come out for meals and refused showers.

  Staff #1 was interviewed and stated Tenant #1 began to refuse cares two days after moving to the program. Tenant #1 would consistently ask for a room tray and would tell staff to get out of his/her room. The RN directed staff to redirect and come back 15 to 20 minutes later or send in another staff person. Staff #2 was interviewed and stated Tenant #1 occasionally refused morning and evening personal and health related cares. Tenant #1 would refuse to get up in the morning. Staff #3 was interviewed and stated Tenant #1 would routinely refuse personal and health related cares. Staff #3 stated Tenant #1 was difficult. Tenant #1 wanted to lie around and would be oppositional and would do anything not to get out of bed.

  Tenant #1's initial service plan of 10-4-11 was updated on 10-6-11 and indicated Tenant #1 needed assistance with activities of daily living (ADLs), No other interventions were established related to Tenant #1's compliance or behavior. The service plan was updated on 11-8-11, after a hospitalization of 11-2-11 and again on

11-23-11, following a hospitalization of 11-22-11. Interventions related to Tenant #1's non-compliance with medication administration, refusal of cares and inappropriate verbal abuse toward staff were not established in each of the updated service plans. Each of the service plans listed above indicated Tenant #1 may attend activities of his/her choice despite having a GDS of four indicating moderate cognitive decline.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum. (a) The tenant's identified needs and preferences for assistance. (d) For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26(4)(a)(d))